(Office Use only) _______Health Form _______Registration Form _______Registration Fee Paid

The Relief Zone
Community Youth Center

2020-2021 TRZ CARDINAL CARE
REGISTRATION FORM
(One child per form/ new form each year)

The Relief Zone Inc.
5 Frew Run St. Box 334
Frewsburg, NY 14738
716-569-2614
trz@thereliefzone.org
www.thereliefzone.org

Name of Child: ______________________________________ Gender: _____ Male _____ Female

Grade:_______Age:_______Date of Birth: / / ___________ Teacher:___________________________

Family Mailing Address: _______________________________________

_____________________________Zip:____

Ethnicity (Please check those that apply): ___Native American ___Caucasian ___African American/Black ___Asian __Hispanic/Latino __Prefer not to answer

Parent or
Guardian:____
Relationship to child:___________________________________
Home Phone:____
Cell Phone:____
Employer:____
Work phone:____
Email Address:____
Does this person reside with the child? YES NO

Parent or
Guardian: ____
Relationship to child: ____
Home Phone:____
Cell Phone:____
Employer: ____
Work Phone: ____
Email Address: ____
Does this person reside with the child? YES NO

Authorized Person for Pick Up/Emergency

Name: ____ Relationship_______________________________________
Address: ____ Phone #s: _______________________ _______________________

Name: ____ Relationship_______________________________________
Address: ____ Phone #s: _______________________ _______________________

Name: ____ Relationship_______________________________________
Address: ____ Phone #s: _______________________ _______________________

DAYS ATTENDING: (please mark in bubbles which days your child will attend)

MONDAYS, ◯ TUESDAYS, ◯ WEDNESDAYS, ◯ THURSDAYS, ◯ FRIDAYS, ◯ ONLY WITH NOTE ◯

Payments are due at the beginning of each week and can be made by check, cash, venmo, or paypal. (www.thereliefzone.org)

I give The Relief Zone and RCS Staff permission to share information regarding my child, so that the staff may better understand any needs my child may have.

Signature______________________________________DATE____

Important – This Box Must Be Completed For TRZ Program Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted.

Publicity photos may be taken throughout the program duration. I allow my child to be included in photos.

Report card data and NWEA-MAP scores results are needed for program data collection; names of individual students are not disclosed, but needed for TRZ to apply for funding. I allow my child's data to be collected.

Authorization for Treatment:

I give my child permission to attend TRZ Cardinal Care After School Program held at Gail N. Chapman Elementary School, 22 Main Street, Randolph, NY 14772. I understand the program rules. I hereby give permission to staff to assist in the application of sunscreen to my child if necessary. By signature below, I hereby release TRZ from all responsibility and liability for any injury or illness my child may sustain. In the event of a medical emergency, I give an adult leader of this program consent to any medical treatment my child may require.

I give permission to the medical personnel selected by the director to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization, for the person named above.

The completed forms may be photocopied.

Signature of Parent or Guardian ____Date __________

I give permission for the school nurse to provide TRZ Cardinal Care with a copy of my child's immunization record.

Signature____Date________________

Please Complete the following questions. Be sure to provide an explanation where needed.				
1.	Is your child physically, mentally, and behaviorally able to participate in TRZ's School Age Child Care Program?		YES	NO
	If NO, please explain?			
2.	Does your child have any condition requiring special attention?		YES	NO
	If YES, please explain?			
3.	Does your child have an Individual Education Plan (IEP) or is being evaluated for one? (If YES, provide a copy of IEP)		YES	NO
4.	Has your child had an illness/injury within the last year or an on-going condition which we should be aware of?		YES	NO
	If YES, please explain?			
5.	Is your child allergic to bee stings? (If YES, Medication Consent is needed)	UNKNOWN	YES	NO
6.	Is your child allergic to any food?		YES	NO
	If YES, Please Explain?			
7.	Is your child allergic to any medications?		YES	NO
	If YES, Please Explain?			
8.	Does your child have any other allergies (i.e. seasonal, etc.) ?		YES	NO
	If YES, Please Explain?			
9.	Does your child have asthma? (If YES, Medication Consent is Needed)		YES	NO
10.	Is your child on any medication?		YES	NO
	If YES, Please Explain?			
11.	Does your child have any eye problems and/or wears glasses/contacts?		YES	NO
	If YES, Please Explain?			
12.	Does your child have any hearing problem?		YES	NO
	If YES, Please explain?			
13.	Does your child have any speech problems?		YES	NO
	If YES, Please explain?			
11.	Special needs or "triggers" we might need to know to help with your child's success:			

Family Physician: ____________________ Phone: ____________________

Insurance Carrier: ____________________ Policy #: ____________________